

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031499

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2407

FILED SEP 13 1961

1. PLACE OF DEATH a. COUNTY Saint Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN Clayton	
Length of stay in 1b YRS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6433 San Bonita		d. STREET ADDRESS (If outside, give location) 6433 San Bonita	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSE Middle WOLKOWITZ Last WOLKOWITZ		4. DATE OF DEATH Month August Day 25 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/25/90
9. AGE (last birthday) 71		IF UNDER 1 YEAR Months 71 Days 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Poland	
11. BIRTHPLACE (City and state or country) Poland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Louis Wolkowitz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Louis Wolkowitz-6433 San Bonita	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS		INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 2-1-61 to 8-25-61 and last saw her alive on 8-11-61 Death occurred at 2:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Arnold Danker, M.D. (Degree or title)	
22b. ADDRESS 150 N. MERAGEC, CLAYTON, MO.		22c. DATE SIGNED 8/25/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/27/61	
23c. NAME OF CEMETERY OR CREMATORY United Hebrew Temple Cem.		23d. LOCATION (City, town, or county) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Herman Rindskopf, Inc. 5216 Delmar		25. DATE RECD. BY LOCAL REG. 8-26-61	
26. REGISTRAR'S SIGNATURE [Signature]		27. REGISTRAR'S SIGNATURE [Signature]	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John Ketter

Licensed Embalmer No. 3880

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.